

Physician Voluntary Reporting Program (PVRP) Background and General Information

Background

As part of its overall quality improvement efforts, CMS is launching the Physician Voluntary Reporting Program (PVRP). This new program builds on Medicare's comprehensive efforts to substantially improve the health and function of our beneficiaries by preventing chronic disease complications, avoiding preventable hospitalizations, and improving the quality of care delivered. Under the voluntary reporting program, physicians who choose to participate will help capture data about the quality of care provided to Medicare beneficiaries, in order to identify the most effective ways to use the quality measures in routine practice and to support physicians in their efforts to improve quality of care. Voluntary reporting of quality data through the PVRP will begin in January 2006. Reporting using specified CPT Category II codes will be effective April 1, 2006.

Policy

As noted by CMS Administrator Mark B. McClellan, M.D., Ph.D. in his testimony before the House Ways and Means Subcommittee on Health on September 29, 2005, CMS believes that an important component of delivering high quality care is the ability to measure and evaluate quality. Accordingly, CMS is committed to the development of reporting and payment systems that will support and reward quality.

Providing quality health care to Medicare beneficiaries is a high priority for President Bush and the Department of Health and Human Services. CMS is also committed to assuring quality of care for all Americans. To that end, CMS has developed several quality initiatives that provide information on the quality of care across different settings, including hospitals, skilled nursing facilities, home health agencies, and dialysis facilities for end stage renal disease. The quality initiatives aim to empower providers and consumers with information that would support the overall delivery and coordination of care, and ultimately to support new payment systems that provide more financial resources to provide better care, rather than simply paying based on the volume of services.

The PVRP would initiate the process by which physicians who choose to participate would begin reporting quality data and be able to receive feedback on their performance, as well as to provide input on how quality reporting can be improved and made even less burdensome. These steps are an important step in enabling CMS to provide better support for physicians' efforts to deliver high-quality care.

Reporting Infrastructure

CMS has developed the underlying infrastructure so that voluntary reporting of quality measures can begin by January 2006, using the existing administrative system for physician claims.

While the usual source of the clinical data for quality measures is retrospective chart abstraction, data collection through this process can be burdensome. Consequently, the

voluntary reporting program will focus on ways to obtain valid quality measures as efficiently as possible.

Electronic health records (EHRs) will greatly facilitate clinical data reporting and performance improvement in the future but its adoption is not currently widespread. CMS is working with physicians to achieve the goal of adopting EHRs in their offices, building on reporting based on the pre-existing claims based system will be used for reporting data under the PVRP. The utilization of a pre-existing reporting system will minimize the burden on physicians.

Physicians can begin providing voluntary information for constructing evidence-based quality measures for the Medicare population through a defined set of HCPCS codes, known as G-codes and CPT Category II codes (only for specified measures). These codes can be reported on the pre-existing physician claim form. These new codes will supplement the usual claims data with clinical data that can be used to measure the quality of services rendered to beneficiaries.

The G-code reporting is an interim reporting method until electronic submission of clinical data through EHRs replaces this process. Medicare expects to work with some physician groups that have already adopted EHRs to assist with this transition.

Medicare's contracted Quality Improvement Organizations (QIOs) are helping physicians move toward a more dynamic and evolving public reporting and pay-for-performance quality improvement environment. In specific, QIOs are providing assistance to help physicians create systems so that the measures can be more easily reported.

Development of Measures

Measuring and evaluating quality requires the development of clinically valid quality measures. Effective measures for performance measurement, quality improvement, disease prevention, and public reporting should be valid, reliable, evidence-based, and relevant for consumers, clinicians and purchasers. In addition, such measures must be developed through open and transparent processes and implemented in a realistic manner with minimal burden on physicians so as not to discourage appropriate care.

The PVRP will begin to phase in quality performance measures that are consistent with these requirements. PVRP consists of 36 evidence-based clinically valid measures which have been part of the guidelines endorsed by physicians and the medical specialty societies and are the result of extensive input and feedback from physicians and other quality care experts. In an effort to decrease reporting burden, CMS has excerpted a 16 Measure Core Starter Set from the 36 Full Measure Set. Physicians recognize the importance of these measures for the management of their patients' care, providing CMS with a strong starting point for the voluntary program.

CMS intends to pursue further development and refinement of the remaining 20 measures within the 36 Full Measure Set. Furthermore, additional quality measures are under development and could be phased-in for reporting later in 2006. It is anticipated that the

PVRP will be expanded to include these consensus measures after they are endorsed and implemented.

Quality Measures

The 16 quality measures are arranged in sets of measures, with multiple G-codes and CPT Category II codes (where specified) in each set. The physician will report the appropriate G-code or CPT Category II code that represents the clinical services provided with regard to a specific measure set.

Each measure set has a defined numerator (the appropriate G-code or CPT Category II code) and a denominator (specifically defined according to the appropriate services or condition), which will be used to calculate performance.

The objective of the PVRP is to help physicians obtain information they can use to improve quality and avoid unnecessary costs. Thus, CMS will provide feedback to physicians on their level of performance based upon the data submitted through this voluntary effort. This feedback may begin as early as summer 2006.

Physician Use of G-codes and CPT Category II codes - General Information

- G-codes, when applicable, should be reported in addition to CPT and ICD-9 codes required for appropriate claims coding.
- CPT Category II codes, when applicable, should be reported alone OR with the appropriate performance exclusion modifier code 1P, 2P, or 3P.
 - Performance Measure Exclusion Modifiers
 - 1P Medical Reasons:
 - (a) not indicated (absence of organ/limb, already received/performed, other)
 - (b) contraindicated (patient allergic history, potential adverse drug interaction, other)
 - 2P Patient Reasons:
 - (a) patient declined
 - (b) economic, social, or religious reasons
 - (c) other patient reason
 - 3P System Reasons:
 - (a) resources to perform the services are not available
 - (b) insurance coverage/payor-related limitations
 - (c) other reasons attributed to health care delivery system
- G-codes and CPT Category II codes do NOT substitute for CPT and ICD-9 codes requirements for payment.
- G-codes and CPT Category II codes are not associated with a separate fee, and will NOT be individually compensated. These codes are for voluntary reporting purposes only. Physicians should NOT charge for these codes.
- G-codes and CPT Category II codes are not specialty specific. Therefore, a medical specialty may report G-codes and/or CPT Category II codes classified under other

specialties; however, CMS anticipates that the reporting of certain G-codes and CPT Category II codes will be predominated by certain specialties.

- The failure to provide a G-code and/or CPT Category II code will NOT result in denial of a claim that would otherwise be approved. Thus submission of a G code and/or CPT Category II codes is voluntary.

Although reporting is voluntary, physicians are encouraged to submit G-codes and/or CPT Category II codes when applicable. The potential advantages to the physician include receiving feedback reports for calculated measures that will promote quality improvement for the physician practice and allowing the physician the opportunity to improve the accuracy of data submission in a voluntary setting.

Physician Use of G-codes – When to report

G-codes and/or CPT Category II codes are reportable when all of the following circumstances are met:

- The G-code and/or CPT Category II code reported on the claim relates to a covered diagnosis, covered treatment(s) or covered preventive service(s) that are applicable to the beneficiary.
- The G-code and/or CPT Category II code is directly relevant to the specific service(s) provided to the beneficiary by the practitioner reported on the claim.
- The G-code and/or CPT Category II code represents medically necessary and appropriate medical practice under the circumstances.
- The basis for the G-code and/or CPT Category II code is documented in the beneficiary medical record.

CMS Calculation of quality measures using G-codes and CPT Category II codes

As part of this voluntary program, CMS will calculate the reporting rate for physicians. For those who participate in the voluntary program, CMS will provide feedback information to physicians in an effort to assist with improving their data accuracy and reporting rate. The reporting rate is calculated as a percentage for each of the 16 measures.